Nursing Home Conditions in the 14th Congressional District of New York: Many Homes Fail to Meet Federal Standards for Adequate Care

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Prepared for Rep. Carolyn B. Maloney

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EXECUTIVE SUMMARY

Many families are becoming increasingly concerned about the conditions in nursing homes. Federal law requires that nursing homes "provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." But recent studies by the U.S. General Accounting Office and others have indicated that many nursing homes fail to meet federal health standards.

To address these growing concerns, Rep. Carolyn B. Maloney asked the Special Investigations Division of the minority staff of the Committee on Government Reform to investigate the conditions in nursing homes in her district, the 14th Congressional District of New York. This district is located in New York City and includes portions of Manhattan and Queens. During the time period covered by this report, there were ten nursing homes in the 14th Congressional District accepting residents covered by Medicaid or Medicare. These homes served over 3,000 residents. This is the first congressional report to evaluate their compliance with federal nursing home standards.

The report finds that there have been serious deficiencies in many of the nursing homes in the 14th Congressional District. Eight of the ten nursing homes in the district violated federal health standards during recent state inspections. Moreover, seven of the ten nursing homes had violations that caused actual harm to residents.

A. Methodology

Under federal law, the U.S. Department of Health and Human Services contracts with the states to conduct annual inspections of nursing homes and to investigate nursing home complaints. These inspections assess whether nursing homes are meeting federal standards of care, such as preventing residents from developing pressure sores (commonly known as bed sores), providing sanitary living conditions, and protecting residents from accidents.

This report is based on an analysis of annual inspections and complaint investigations of ten nursing homes in the 14th Congressional District that were conducted between August 2000 and November 2002. During this time period, one facility in the district opened and one facility closed.

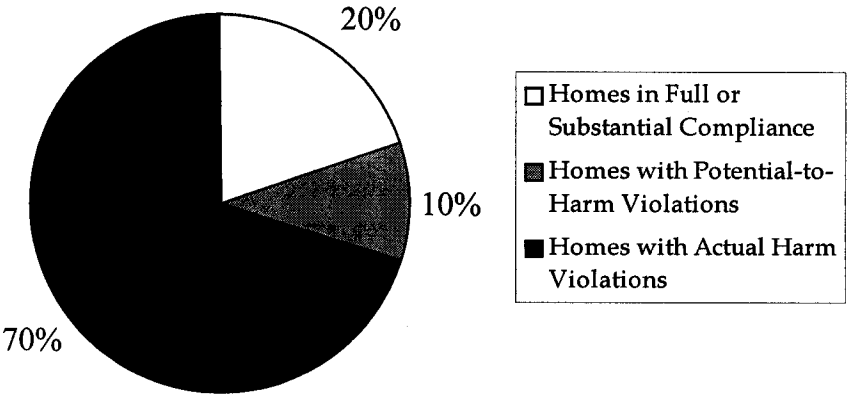
Because this report is based on recent state inspections, the results are representative of current nursing home conditions in the region as a whole. However, conditions in individual homes can change. New management or enforcement activities can bring rapid improvement; other changes can lead to sudden deterioration. For this reason, the report should be considered a representative "snapshot" of overall conditions in nursing homes in the 14th Congressional District, not an analysis of current conditions in any specific home. At any individual nursing home, conditions could be better – or worse – today than when the most recent inspection was conducted.

B. Findings

All but two of the nursing homes in the 14th Congressional District violated federal standards governing quality of care. State inspectors consider a nursing home to be in full compliance with federal health standards if no violations are detected during the annual inspection or a complaint investigation. They consider a nursing home to be in "substantial compliance" with federal standards if the violations at the facility do not have the potential to cause more than minimal harm. Of the ten nursing homes in the 14th Congressional District, only two facilities were found to be in full compliance with federal standards during the most recent annual inspections. No homes were in substantial compliance during the most recent inspections. The eight noncompliant nursing homes had at least one violation with the potential to cause more than minimal harm to residents or worse. On average, each of these eight nursing homes had 6.6 violations of federal quality of care requirements.

Most of the nursing homes in the 14th Congressional District had violations that caused actual harm to residents. Of the ten nursing homes in Rep. Maloney's district, seven facilities had a violation that caused actual harm to nursing home residents during the most recent annual inspections (see Figure 1). The seven nursing homes with actual harm violations served 3,086 residents and are estimated to have received almost $99 million each year in federal and state funds.

Figure 1: Compliance Status of Nursing Homes in the 14th Congressional District



Nursing home conditions in the 14th Congressional District have not improved between annual inspections. Of the ten nursing homes in the district, nine facilities had been inspected at least twice since August 2000. The Special Investigations Division compared the results of the most recent annual inspections of those nine nursing homes, which were conducted between November 2001 and November 2002, and the next most recent inspections of the same

facilities, which were conducted between August 2000 and September 2001. Only one of the nursing homes was found to be in full compliance with federal health requirements in both sets of annual inspections. The remaining eight facilities had at least one violation that had the potential to cause more than minimal harm to residents or worse.

The state inspection reports documented serious care problems. Representatives of nursing homes argue that the "overwhelming majority" of nursing homes meet government standards and that many violations are actually trivial in nature. To assess these claims, this report examined in detail the inspection reports from the eight nursing homes in Rep. Maloney's district that were not in compliance with federal standards. The inspection reports for these homes documented that the actual harm violations cited by state inspectors involved serious neglect and mistreatment of residents. Moreover, the inspection reports documented many other serious violations that would be of great concern to families, but were not classified as causing actual harm, indicating that significant deficiencies can exist at nursing homes cited for potential-to-harm violations.

Examples of the violations documented by inspectors in the 14th Congressional District of New York included the following:

- Failure to provide proper nutrition and hydration, leading to the death of a resident in one instance;
- Failure to provide proper medical care;
- Failure to prevent falls and accidents; and
- Failure to protect residents from physical abuse.

I. GROWING CONCERNS ABOUT NURSING HOME CONDITIONS

Increasingly, Americans are facing difficult decisions about nursing homes. The decision to move a loved one into a nursing home raises very real questions about how the resident will be treated at the nursing home. Will the resident receive proper food and medical treatment? Will the resident be assisted by staff with basic daily activities, such as bathing and dressing? Will the resident be able to live out his or her life with dignity and compassion? These are all legitimate concerns – and they are becoming more common as America ages.

In 1966, there were 19 million Americans 65 years of age and older.[1] That figure has now risen to 35 million Americans, 12.4% of the population.[2] By 2030, the number of Americans aged 65 and older is expected to increase to 70.3 million, 20% of the population.[3]

This aging population will increase demands for long-term care. In 2000, there were 1.5 million people living in more than 17,000 nursing homes in the United States.[4] The Department of Health and Human Services (HHS) has estimated that 43% of all 65 year olds will use a nursing home at some point during their lives. Of those who do need the services of a nursing home, more than half will require stays of over one year, and over 20% will be in a nursing home for more than five years.[5] By 2050, the total number of nursing home residents is expected to quadruple from the current 1.5 million to 6.6 million.[6]

Most nursing homes are run by private, for-profit companies. Of the 17,023 nursing homes in the United States in 2000, over 11,000 (65%) were operated by for-profit companies.[7] During the 1990s, the nursing home industry witnessed a trend toward consolidation as large

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[1]Centers for Medicare & Medicaid Services (CMS), *Medicare Enrollment: National Trends, 1966 - 2001* (available at http://cms.hhs.gov/statistics/enrollment/natltrends/hi_smi.asp).

[2]U.S. Census Bureau, *Profiles of General Demographic Characteristics: 2000 Census of Population and Housing, United States* (May 2001).

[3]U.S. Census Bureau, *Projections of the Total Resident Population by 5-Year Age Groups, and Sex with Special Age Categories: Middle Series, 2025 to 2045* (December 1999).

[4]American Health Care Association, *Facts and Trends: The Nursing Facility Sourcebook*, vii (2001).

[5]Health Care Financing Administration, Report to Congress, *Study of Private Accreditation (Deeming) of Nursing Homes, Regulatory Incentives and Non-Regulatory Initiatives, and Effectiveness of the Survey and Certification System*, §1.1 (July 21, 1998).

[6]*Facts and Trends*, *supra* note 4, at vii.

[7]*Id.* at viii.

national chains bought up smaller chains and independent homes. As of December 2001, the six largest nursing home chains in the United States operated 2,040 facilities with over 243,000 beds.[8]

Through the Medicaid and Medicare programs, the federal government is the largest payer of nursing home care. Under the Medicaid program, a federal-state health care program for the needy, all nursing home and related expenses are covered for qualified individuals. Under the Medicare program, a federal program for the elderly and certain disabled persons, skilled nursing services are partially covered for up to 100 days. In 2003, it is projected that federal, state, and local governments will spend $67.9 billion on nursing home care, of which $53.8 billion will come from Medicaid payments ($34.3 billion from the federal government and $19.5 billion from state governments) and $11.5 billion from federal Medicare payments. Private expenditures for nursing home care are estimated to be $39.2 billion ($26.9 billion from residents and their families, $8 billion from private insurance policies, and $4.3 billion from other private funds).[9] The overwhelming majority of nursing homes in the United States receive funding through either the Medicaid program or the Medicare program, or both.

Under federal law, nursing homes that receive Medicaid or Medicare funds must meet federal standards of care. Prior to 1987, these standards were relatively weak: they focused on a facility's ability to provide adequate care, rather than on the level of care actually provided. In 1986, a landmark report by the Institute of Medicine found widespread abuses in nursing homes.[10] This report, coupled with national concern over substandard conditions, led Congress to pass comprehensive legislation in 1987 establishing new standards for nursing homes. This law requires nursing homes to "provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."[11]

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[8]Aventis Pharmaceuticals, *Managed Care Digest Series 2002, Nursing Home Chains Reports: The Nation's Largest Nursing Home Chains* (available at http://www.managedcaredigest.com/edigests/inst2002/inst2002.shtml).

[9]All cost projections come from: CMS, *Nursing Home Care Expenditures Aggregate and per Capita Amounts, Percent Distribution and Average Annual Percent Change by Source of Funds: Selected Calendar Years 1980 - 2011* (available at http://cms.hhs.gov/statistics/nhe/projections-2001/t14.asp).

[10]Committee on Nursing Home Regulation, Institute of Medicine, *Improving the Quality of Care in Nursing Homes* (1986). The IOM report concluded: "[I]ndividuals who are admitted receive very inadequate – sometimes shockingly deficient – care that is likely to hasten the deterioration of their physical, mental, and emotional health. They are also likely to have their rights ignored or violated, and may even be subject to physical abuse." *Id.* at 2-3.

[11]42 U.S.C. §1396r(b)(2).

Implementing regulations were promulgated by HHS in 1990 and 1995. The 1987 law and the implementing regulations limit the use of physical and chemical restraints on nursing home residents. They require nursing homes to prevent pressure sores, which are painful wounds or bruises, caused by pressure or friction, that can become infected. They also establish other health standards for nursing homes, such as requiring that residents are properly cleaned and bathed, receive appropriate medical care, and are supervised to prevent falls and accidents. The regulatory requirements are codified at 42 C.F.R. Part 483.

Recently, investigators have begun to examine whether nursing homes are meeting the requirements of the 1987 law and its implementing regulations. The results have not been encouraging. Certain abusive practices documented by the Institute of Medicine in 1986, such as the improper use of physical restraints and antipsychotic drugs, have been reduced.[12] But health violations appear to be widespread. In a series of 1999 reports, the U.S. General Accounting Office (GAO), an investigative arm of Congress, found that "more than one-fourth of the homes had deficiencies that caused actual harm to residents or placed them at risk of death or serious injury";[13] that these incidents of actual harm "represented serious care issues . . . such as pressure sores, broken bones, severe weight loss, and death";[14] and that "[s]erious complaints alleging that nursing home residents are being harmed can remain uninvestigated for weeks or months."[15]

Other researchers have reached similar conclusions. In July 1998, Professor Charlene Harrington of the University of California-San Francisco, a leading nursing home expert, found that the current level of nursing home staffing is "completely inadequate to provide care and supervision."[16] In March 1999, the inspector general of HHS found an increasing number of

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[12]The percent of residents in physical restraints dropped from 38% in 1987 to 15% in 1998; the percent of residents being administered anti-psychotic drugs dropped from 33% to 16% during the same time period. Testimony of Michael Hash, Deputy Administrator of HCFA, before the Senate Special Committee on Aging (July 28, 1998).

[13]GAO, *Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*, 3 (March 1999).

[14]GAO, *Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit*, 2 (June 1999).

[15]GAO, *Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents*, 2 (March 1999).

[16]Testimony of Charlene Harrington before the Senate Special Committee on Aging (July 28, 1998).

serious deficiencies relating to the quality of resident care.[17] And in March 2002, HHS released a study that found that over 90% of nursing homes have staffing levels that are too low to provide adequate care.[18]

In light of the growing concern about nursing home conditions, Rep. Carolyn B. Maloney asked the Special Investigations Division of the minority staff of the Government Reform Committee to investigate the prevalence of health violations in nursing homes in her congressional district. Rep. Maloney represents the 14th Congressional District of New York, which is located in New York City and includes portions of Manhattan and Queens. This is the first congressional report to comprehensively investigate nursing home conditions in the 14th Congressional District.

II. METHODOLOGY

To assess the conditions in nursing homes in Rep. Maloney's congressional district, this report analyzed three sets of data: (1) the Online Survey, Certification, and Reporting (OSCAR) database maintained by HHS, which compiles the results of nursing home inspections; (2) the nursing home complaint database maintained by HHS, which contains the results of state complaint investigations; and (3) state inspection reports from eight nursing homes in Rep. Maloney's district.

A. Determination of Compliance Status

Data on the compliance status of nursing homes in the 14th Congressional District comes from the OSCAR database and the complaint database. These databases are compiled by the Centers for Medicare and Medicaid Services (CMS), a division of HHS.[19] CMS contracts with states to conduct annual inspections of nursing homes and to respond to nursing home complaints. During these inspections and investigations, the inspection team interviews a sample of residents, staff members, and family members. The inspection team also reviews a sample of clinical records. Violations of federal standards observed by the inspectors are cited by the inspection team, reported by the states to CMS, and compiled in the OSCAR and complaint databases.[20]

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[17]HHS Office of Inspector General, *Nursing Home Survey and Certification: Deficiency Trends* (March 1999).

[18]HHS Report to Congress, *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Phase II Final Report*, 1-6 (Winter 2001).

[19]Prior to 2001, CMS was known as the Health Care Financing Administration (HCFA).

[20]In addition to tracking the violations at each home, the OSCAR database compiles the following information about each home: the number of residents and beds; the type of ownership

The OSCAR and complaint databases use a ranking system in order to identify the violations that pose the greatest risk to residents. The rankings are based on the severity (degree of actual harm to residents) and the scope (the number of residents affected) of the violation. As shown in Table 1, each violation is given a letter rank, A to L, with A being the least serious (an isolated violation that poses minimal risks to residents) and L being the most serious (a widespread violation that causes or has the potential to cause death or serious injury). Homes with violations in categories A, B, or C are considered to be in "substantial compliance" with the law. Homes with violations in categories D, E, or F have the potential to cause "more than minimal harm" to residents. Homes with violations in categories G, H, or I are causing "actual harm" to residents. And homes with violations in categories J, K, or L are causing (or have the potential to cause) death or serious injury to residents.

Table 1: CMS's Scope and Severity Grid for Nursing Home Violations

Severity of Deficiency	Scope of Deficiency		
	Isolated	*Pattern of Harm*	*Widespread Harm*
Potential for Minimal Harm	A	B	C
Potential for More Than Minimal Harm	D	E	F
Actual Harm	G	H	I
Actual or Potential for Death/Serious Injury	J	K	L

To assess the compliance status of nursing homes in the 14th Congressional District, this report analyzed the OSCAR database to determine the results of the most recent annual inspections of each nursing home recently operating in the region.[21] These inspections were conducted between November 2001 and November 2002. In addition, the report analyzed the complaint database to determine the results of any nursing home complaint investigations that were conducted during this same time period. Finally, the report evaluated the next most recent set of inspection reports for the nine nursing homes that had been in operation for more than one year; these inspections were conducted between August 2000 and September 2001. Following the approach used by GAO in its reports on nursing home conditions, this report focused primarily on violations ranked in category G or above. These are the violations that cause actual harm to residents or have the potential to cause death or serious injury.

(*e.g.*, for-profit or nonprofit); whether the home accepts residents on Medicare and/or Medicaid; and the characteristics of the resident population (*e.g.*, number of incontinent residents, number of residents in restraints). To provide public access to this information, CMS maintains a website (http://www.medicare.gov/nhcompare/home.asp) where the public can obtain data about individual nursing homes.

[21]These results include one facility that opened in 2002 and one facility that closed in 2002.

B. Analysis of State Inspection Reports

In addition to analyzing the data in the OSCAR and complaint databases, this report analyzed a sample of the actual inspection reports prepared by state inspectors of nursing homes in the 14th Congressional District. These inspection reports, prepared on a CMS form called "Form 2567," contain the inspectors' documentation of the conditions at each nursing home.

The Special Investigations Division selected for review the inspection reports from the eight nursing homes in the district that were not in compliance with federal standards. For each of these facilities, the most recent state inspection report was obtained from the New York State Department of Health. For several of these nursing homes, the Special Investigations Division also obtained reports of other annual inspections and complaint investigations conducted by the New York State Department of Health over the past few years. These reports were then reviewed to assess the severity of the violations documented by the state inspectors.

C. Interpretation of Results

The results presented in this report are representative of current conditions in nursing homes in Rep. Maloney's district. In the case of any individual home, however, current conditions may differ from those documented in the most recent inspection report, especially if the report is more than a few months old. Nursing home conditions can change over time. New management or enforcement activities can rapidly improve conditions; other changes can lead to sudden deterioration. According to GAO, many nursing homes with serious deficiencies exhibit a "yo-yo pattern" of noncompliance and compliance: after a home is cited for deficiencies, it briefly comes into compliance to avoid fines or other sanctions, only to slip into noncompliance after the threat of sanctions is removed.[22]

For this reason, this report should be considered a representative "snapshot" of nursing home conditions in the 14th Congressional District. It is not intended to be – and should not be interpreted as – an analysis of current conditions in any individual nursing home.

The report also should not be used to compare violation rates in nursing homes in Rep. Maloney's district with violation rates in other states. Data regarding violation rates comes from state inspections that can vary considerably from state to state in their thoroughness and ability to detect violations. According to GAO, "[c]onsiderable inter-state variation still exists in the citation of serious deficiencies."[23]

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[22]GAO, *Nursing Homes: Additional Steps Needed*, *supra* note 13, at 12-14.

[23]GAO, *Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives*, 16 (September 2000).

III. NURSING HOME CONDITIONS IN THE 14th CONGRESSIONAL DISTRICT

There were ten nursing homes in the 14th Congressional District, during the time period covered by this report, that accepted residents covered by Medicaid or Medicare. These nursing homes had 3,506 beds that were occupied by 3,360 residents during the most recent round of annual inspections. The majority of these residents, 2,813, relied on Medicaid to pay for their nursing home care. Medicare paid the cost of care for 203 residents. Four of the ten nursing homes in Rep. Maloney's district were private, for-profit nursing homes.

The results of this investigation indicate that the conditions in these nursing homes often fall substantially below federal standards. Many residents are not receiving the care that their families expect and that federal law requires.

A. Prevalence of Violations

Only two of the nursing homes in the 14th Congressional District were found by the state inspectors during the most recent annual inspections to be in full compliance with federal health requirements; none were found to be in substantial compliance. The other eight nursing homes had at least one violation that had the potential to cause more than minimal harm to their residents or worse. Seven of these facilities had violations that caused actual harm to residents. No facilities were cited for violations that had the potential to cause death or serious injury. Table 2 summarizes these results.

Table 2: Nursing Homes in the 14th Congressional District Had Numerous Violations that Placed Residents at Risk

Most Severe Violation Cited by Inspectors	Number of Homes	Percent of Homes	Number of Residents
Complete Compliance (No Violations)	2	20%	34
Substantial Compliance (Risk of Minimal Harm)	0	0%	0
Potential for More than Minimal Harm	1	10%	240
Actual Harm to Residents	7	70%	3,086
Actual or Potential Death/Serious Injury	0	0%	0

All eight noncompliant nursing homes were cited for multiple violations. State inspectors found a total of 53 violations in the eight facilities that were not in full compliance with federal requirements, an average of 6.6 violations per noncompliant home.

B. Prevalence of Violations Causing Actual Harm to Residents

According to GAO, some of the greatest safety concerns are posed by nursing homes with violations that cause actual harm to residents or have the potential to cause death or serious injury. These are homes with violations ranked at the G-level or above. As shown in Table 2, the results of the most recent annual inspections revealed that seven nursing homes in Rep.

Maloney's district had violations that caused actual harm. These seven facilities served 3,086 residents – over 90% of the nursing home residents in the district – and are estimated to have received almost $99 million in federal and state funds each year.

C. Past Prevalence of Violations

In order to determine whether nursing home conditions in the 14th Congressional District have improved, this report compared the most recent annual inspections and the next most recent inspections of the nine facilities that had been in operation for more than one year. This analysis found that nursing home conditions have not improved over the past few years. The most recent annual inspections, conducted between November 2001 and November 2002, showed that only one of the nine facilities was found to be in full compliance with federal health requirements; none were found to be in substantial compliance. During the next most recent inspections, conducted between August 2000 and September 2001, only one of the nursing homes was found to be in full compliance and none were found to be in substantial compliance. The remaining eight nursing homes had at least one violation that had the potential to cause more than minimal harm to their residents or worse. The eight noncompliant nursing homes inspected between August 2000 and September 2001 were cited for a total of 45 violations, an average of 5.6 violations per noncompliant facility. According to the HHS database, four of those nursing homes had violations that caused actual harm to residents.[24]

D. Potential for Underreporting of Violations

The report's analysis of the prevalence of nursing home violations was based in large part on the data reported to CMS in the OSCAR database. According to GAO, even though this database is "generally recognize[d] . . . as reliable," it may "understate the extent of deficiencies."[25] One problem, according to GAO, is that "homes could generally predict when their annual on-site reviews would occur and, if inclined, could take steps to mask problems otherwise observable during normal operations."[26] A second problem is that state inspectors often miss significant violations. A recent GAO report found that when federal inspectors inspect nursing homes after state inspectors, the federal inspectors find more serious care problems than the state inspectors in 70% of the nursing homes. The federal inspectors also find

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[24]However, the Special Investigations Division discovered an additional facility that was cited for a J-level violation – a violation having the potential to cause death or serious injury – that was not accounted for in the HHS database. According to the HHS database, the most serious violation cited at that facility was a D-level violation – a violation that has the potential to cause more than minimal harm.

[25]GAO, *Nursing Homes: Additional Steps Needed*, *supra* note 13, at 30.

[26]GAO, *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight*, 4 (July 1998).

many more violations of federal health standards.[27] Consequently, the prevalence of violations causing potential or actual harm may be higher than what is reported in this study.

IV. DOCUMENTATION OF VIOLATIONS IN THE INSPECTION REPORTS

Representatives of the nursing home industry have alleged that the actual harm violations cited by state inspectors are often insignificant. The American Health Care Association (AHCA), which represents for-profit nursing homes, has stated that the "overwhelming majority of nursing facilities in America meet or exceed government standards for quality."[28] AHCA also claims that deficiencies cited by inspectors are often "technical violations posing no jeopardy to residents" and that the current inspection system "has all the trademarks of a bureaucratic government program out of control."[29] As an example of such a technical violation, AHCA has claimed that the cancellation of a painting class would constitute a serious deficiency.[30]

At the national level, these assertions have proven to be erroneous. In response to AHCA's criticisms, GAO undertook a review of 201 random actual harm violations from 107 nursing homes around the country. GAO found that nearly all of these deficiencies posed a serious harm to residents. Of the 107 homes surveyed, 98% were found to have a deficiency that caused actual harm, including "pressure sores, broken bones, severe weight loss, burns, and death."[31] GAO found that many of the deficiencies affected multiple residents and that two-thirds of these homes had been cited for violations that were as severe as or even more severe than violations cited in previous or subsequent annual inspections.[32]

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[27]*Nursing Homes: Sustained Efforts Are Essential, supra* note 23, at 43.

[28]Statement of Linda Keegan, Vice President, AHCA, regarding Senate Select Committee on Aging Forum: "Consumers Assess the Nursing Home Initiatives" (Sept. 23, 1999).

[29]AHCA Press Release, *AHCA Responds to Release of General Accounting Office Study on Enforcement* (Mar. 18, 1999).

[30]Letter from Sen. Charles E. Grassley to William Scanlon (GAO), 1 (May 27, 1999).

[31]GAO, *Nursing Homes: Proposal to Enhance Oversight, supra* note 14, at 2.

[32]*Id.* at 6. A subsequent GAO study in August 1999 examined several examples provided by AHCA of serious deficiencies cited by state inspectors that AHCA asserted were of questionable merit. For those deficiencies that it had sufficient facts to analyze, GAO concluded that the regulatory actions taken against these homes were merited. The GAO report stated: "In our analysis of the cases that AHCA selected as 'symptomatic of a regulatory system run amok,' we did not find evidence of inappropriate regulatory actions." Letter from Kathryn G. Allen (GAO) to Sen. Charles E. Grassley, 2 (Aug. 13, 1999).

This report undertook a similar analysis at the local level. To assess the severity of violations at nursing homes in the 14th Congressional District, the Special Investigations Division examined the annual inspection reports and complaint investigations for the eight nursing homes in the district that had been cited for violations of federal health standards. These reports showed that the actual harm violations cited by state inspectors involved numerous examples of serious neglect and mistreatment of residents. The violations documented in the reports included improper nutrition and hydration, improper medical care, preventable falls and accidents, and physical abuse. In the most serious instance, a violation led to the death of a resident.

One of the most disturbing findings from the review of the inspection reports was that the serious violations were not limited to violations that caused actual harm (G-level and above). To the contrary, many of the violations classified as having a "potential for more than minimal harm" (violations at the D, E, or F levels) involved conditions and mistreatment that would be regarded by families of residents as unacceptable. The severity of these violations indicates that serious deficiencies can exist even at nursing homes that are not cited for actual harm violations.

The following discussion summarizes some examples of the violations documented in the inspection reports.

A. Failure to Provide Proper Nutrition and Hydration

Several nursing homes in the 14th Congressional District failed to provide proper nutrition and hydration to their residents.[33] In the most serious case, a resident died after a staff member gave him solid food and left him unattended in the dining room. The resident, who had been diagnosed with dementia, had a physician's order requiring that he be given only pureed food. Nonetheless, the facility's recreation therapist gave the resident a danish and then left the dining room. Despite a facility policy requiring a nurse aide to be present at all meals, 16 to 18 residents were left unsupervised. When the recreation therapist returned with a nurse aide, the resident was "hanging over the side of his chair gasping for air" with "his face turned blue." The resident died less than an hour later.[34]

At another facility, a resident developed several serious pressure sores because she was not provided with nutritional intervention. The resident suffered a 17% weight loss, her protein level dropped, and she weighed only 70% of her ideal weight. As a result, the resident developed

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[33]Form 2567 for Nursing Home in Astoria (Dec. 31, 2001) (D-level violation) (this facility subsequently closed); Form 2567 for Nursing Home in New York (July 25, 2001) (G-level violation).

[34]Form 2567 for Nursing Home in New York (Nov. 10, 2000) (J-level violation). This violation was documented in a complaint investigation report obtained directly from the New York State Department of Health. The violation, however, was not accounted for in the database information obtained from HHS. *See* note 24.

several pressure sores that worsened to the most severe type of sore. When asked by state inspectors, the resident's physician stated that protein supplements should have been given to the resident.[35]

State inspectors also cited a facility for failing to treat promptly a resident's dehydration. Even though the resident had been identified as being at risk for dehydration, staff members waited five days before informing the resident's physician of a blood test indicating dehydration. When the physician was finally informed of the result, the resident was "weak and lethargic," had low blood pressure and poor skin elasticity, and had to be given intravenous fluids.[36]

B. Failure to Provide Proper Medical Care

The inspection reports documented a wide array of violations involving improper or inadequate medical care.[37] On one occasion, inspectors found no evidence that a facility checked a diabetic resident's blood sugar level as required by his care plan before giving him insulin, a drug that lowers blood sugar levels. After receiving the insulin, the resident's blood sugar level fell dangerously low, leaving him weak, lethargic, and unable to respond to most stimuli.[38]

At another facility, a resident with an irregular heartbeat did not receive physician-ordered nitroglycerine after complaining of chest pain. A second resident at the facility had a wound that was "oozing" and covered by a soiled dressing. The resident's medical record indicated that wound treatment had been discontinued two weeks earlier, despite a doctor's order directing treatment.[39]

The same facility was later cited for improper pain management when state inspectors observed a resident complaining of pain during treatment of a severe pressure sore. The resident told the nurse providing the treatment: "You are hurting me. Give me something for pain, please." The nurse replied that she had already given the resident pain medication, indicated that

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[35]Form 2567 for Nursing Home in New York (Aug. 15, 2002) (G-level violation).

[36]Form 2567 for Nursing Home in New York (Nov. 12, 2002) (G-level violation).

[37]Form 2567 for Nursing Home in New York (May 13, 2002) (G-level violation); Form 2567 for Nursing Home in New York (Dec. 14, 2001) (E-level and G-level violations); Form 2567 for Nursing Home in New York (Nov. 28, 2001) (D-level violation); Form 2567 for Nursing Home in New York (Apr. 26, 2001) (D-level violation).

[38]Form 2567 for Nursing Home in New York (Sept. 27, 2000) (G-level violation).

[39]Form 2567 for Nursing Home in New York (July 25, 2001) (G-level violation).

it needed time to work, and continued the treatment. The resident stated: "It doesn't make any sense, why are you doing my dressing if I am in pain now?"[40]

C. Failure to Prevent Falls and Accidents

A number of nursing homes were cited for not taking adequate precautions to prevent falls and accidents that resulted in serious injuries such as fractured bones, lacerations, and bruising. One facility was cited for failing to develop appropriate care plans for residents with multiple falls. For example, one resident fell eight times in the first four months after admission, suffering various injuries including a laceration, serious bruising, and a fracture that required hospital care. The day the resident returned from the hospital, she was injured in another fall. Despite the multiple falls, the facility failed to implement an appropriate plan to prevent the resident from falling.[41]

Another facility failed to prevent two residents from falling, even though the residents had been assessed as being at high risk for falls. One resident fell 13 times in less than three months, suffering lacerations and serious bruises. The other resident fell 12 times in less than three months, suffering abrasions, bleeding, and serious bruises. State inspectors found no evidence that the facility adequately supervised the residents to prevent multiple falls.[42]

At a third nursing home, a resident who was assessed as being at high risk for falls suffered fractures and serious bruises as the result of numerous falls and accidents. After eight months of falls and injuries, the facility provided the resident with a body alarm. Just a few months later, the facility stopped using the alarm without first reassessing the resident's risk for falls. Two months after the alarm was discontinued, the resident was "found lying on the floor face down in front of her wheelchair," bleeding from her forehead.[43]

D. Failure to Protect Residents from Physical Abuse

Nursing homes in Rep. Maloney's district also failed to protect residents from physical abuse.[44] One facility failed to revise a resident's care plan to address his continuous aggressive

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[40]Form 2567 for Nursing Home in New York (Aug. 15, 2002) (G-level violation).

[41]Form 2567 for Nursing Home in New York (Feb. 12, 2001) (G-level violation).

[42]Form 2567 for Nursing Home in New York (Mar. 20, 2001) (G-level violation).

[43]Form 2567 for Nursing Home in New York (Sept. 27, 2000) (G-level violation).

[44]Form 2567 for Nursing Home in New York (Nov. 28, 2001) (D-level violation); Form 2567 for Nursing Home in New York (July 25, 2001) (C-level violation); Form 2567 for Nursing Home in New York (Mar. 20, 2001) (G-level violation).

behavior. The male resident, diagnosed with a personality disorder, "struck another resident on the right side of his face" twice and "threatened another resident with violence." The abusive resident also verbally and physically assaulted staff members. Despite a psychiatric recommendation that the resident receive psychological services, inspectors found that no such services had been provided.[45]

E. Other Violations

Facilities were also cited for failure to properly clean and care for residents. At one nursing home, physician orders required that a resident whose leg was in a cast be taken out of bed in a wheelchair. State inspectors found, however, that the resident, who was dependent on staff for all activities of daily living, had not been taken out of bed for over three months.[46]

A resident at a second facility complained that on several occasions she had waited two or more hours for incontinence care after soiling herself. She stated that she would put on her call light two or three times, only to have staff enter her room, turn off the call light, and leave without providing care. While the inspector was interviewing the resident, a nurse aide entered the room and asked the resident if she needed any help. The resident's roommate laughed out loud and said, "[A]s long as I've been here, that is the first time any staff has come in to ask if we need help." The resident agreed.[47]

State inspectors also found other violations that, while not causing immediate harm, reveal the indifferent attitude sometimes displayed by nursing homes towards residents. For example, one facility was cited for failing to protect the dignity of its residents. Inspectors observed one resident, who was completely dependent on staff, wearing pants that were "torn from the waist to the thigh . . . exposing his blue diaper" and a shirt that was torn on the shoulder and under the arm. Inspectors saw the resident a week later wearing the same torn clothing, even though the resident owned clothing that was not torn.[48]

V. CONCLUSION

The 1987 nursing home law was intended to stop abuses in nursing homes by establishing stringent federal standards of care. Although the law and its implementing regulations require appropriate standards of care, compliance by the nursing homes in the 14th Congressional District has been poor. This report reviewed the OSCAR and complaint databases and a sample of actual

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[45]Form 2567 for Nursing Home in New York (Apr. 26, 2001) (D-level violation).

[46]Form 2567 for Nursing Home in New York (Apr. 26, 2001) (D-level violation).

[47]Form 2567 for Nursing Home in New York (Sept. 27, 2000) (G-level violation).

[48]Form 2567 for Nursing Home in New York (Apr. 26, 2001) (D-level violation).

state inspection reports. The same conclusion emerges from both analyses: many nursing homes in the 14th Congressional District are failing to provide the care that the law requires and that families expect.